RULE-MAKING ORDER

CR-103 (June 2004)
(Implements RCW 34.05.360)

Agency: Insurance Commissioner

X **Permanent Rule**
☐ **Emergency Rule**

Effective date of rule:
Permanent Rules
X 31 days after filing.
☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Effective date of rule:
Emergency Rules
☐ Immediately upon filing.
☐ Later (specify) _____

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?
☐ Yes X No If Yes, explain:

Purpose: These amendments will correct technical errors in chapter 284-66 WAC.

Insurance Commissioner Matter No. R 2006-13

Citation of existing rules affected by this order:
Repealed:
Amended: WACs 284-66-063, 284-66-066, 284-66-092, 284-66-142, 284-66-160
Suspended:

Statutory authority for adoption: RCW 48.06.060 and 48.66.165

Other authority :

PERMANENT RULE ONLY (Including Expedited Rule Making)
Adopted under notice filed as WSR 06-22-095 on 2/12/07 (date).
Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: phone ( ) _____
Address: fax ( ) _____
e-mail _____

EMERGENCY RULE ONLY
Under RCW 34.05.350 the agency for good cause finds:
☐ That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.
☐ That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this finding:

Date adopted: February 26, 2007

NAME (TYPE OR PRINT)
Mike Kreidler

SIGNATURE

Mike Kreidler

TITLE
Insurance Commissioner

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: February 26, 2007
TIME: 1:47 PM

WSR 07-06-014

(COMPLETE REVERSE SIDE)

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____

The number of sections adopted at the request of a nongovernmental entity:

	New	_____	Amended	_____	Repealed	_____

The number of sections adopted in the agency's own initiative:

	New	_____	Amended	5	Repealed	_____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	_____	Amended	_____	Repealed	_____

The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	_____	Amended	_____	Repealed	_____

AMENDATORY SECTION (Amending Matter No. R 2004-08, filed 8/4/05, effective 9/4/05)

WAC 284-66-063 Benefit standards for policies or certificates issued or delivered after June 30, 1992. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(1) General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within three months before the effective date of coverage.

(b) A Medicare supplement policy or certificate may not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(c) Each Medicare supplement policy must be guaranteed renewable and:

(i) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the Medicare supplement policy is terminated by the group policy holder and is not replaced as provided under (c)(v) of this subsection, the issuer must offer certificateholders an individual Medicare supplement policy that (at the option of the certificateholder) provides for continuation of the benefits contained in the group policy, or provides for benefits that otherwise meet the requirements of this subsection.

(iv) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer must offer the certificateholder the conversion opportunity described in (c)(iii) of this subsection, or at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(v) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy must offer coverage to all persons covered under the old group policy on its

date of termination. Coverage under the new policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(d) Termination of a Medicare supplement policy or certificate must be without prejudice to any continuous loss that began while the policy was in force, but the extension of benefits beyond the period that the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(e) If a Medicare supplement policy or certificate eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug Improvement and Modernization Act of 2003, the modified policy or certificate is deemed to satisfy the guaranteed renewal requirements of this section.

(f)(i) A Medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four months) that the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to the assistance.

(ii) If the suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate must be automatically reinstituted effective as of the date of termination of the entitlement if the policyholder or certificateholder provides notice of loss of the entitlement within ninety days after the date of the loss and pays the premium attributable to the period.

(iii) Each Medicare supplement policy must provide that benefits and premiums under the policy will be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy must be automatically reinstituted (effective as of the date of loss of coverage within ninety days after the date of the loss).

(g) Reinstitution of the coverages;

(i) May not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Must provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of the suspension. If the suspended Medicare Supplement policy or certificate provided coverage for outpatient prescription drugs,

reinstitution of the policy for Medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) Must provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(2) Standards for basic ("core") benefits common to benefit plans A-J. Every issuer must make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not in place of the basic "core" package.

(a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any medicare benefit period;

(b) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(c) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of ((~~packaged~~)) packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(e) Coverage for the coinsurance amount, or in the case of hospital; outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(3) Standards for additional benefits. The following additional benefits must be included in Medicare supplement benefit plans "B" through "J" only as provided by WAC 284-66-066.

(a) Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(b) Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare

Part A;

(c) Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(d) Eighty percent of the Medicare Part B excess charges: Coverage for eighty percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(e) One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(f) Basic outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a Medicare supplement policy after December 31, 2005.

(g) Extended outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a Medicare supplement policy after December 31, 2005.

(h) Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for eighty percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, that would have been covered by Medicare if provided in the United States and that began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: Coverage for the following preventive health services not covered by Medicare:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from (ii) of this subsection and patient education to address preventive health care measures.

(ii) Preventive screening tests or preventive services, the selection and frequency that is determined to be medically appropriate by the attending physician.

Reimbursement must be for the actual charges up to one hundred percent of the Medicare-approved amount for each service, as if

Medicare were to cover the service as identified in *American Medical Association Current Procedural Terminology (AMA CPT)* codes, to a maximum of one hundred twenty dollars annually under this benefit. This benefit may not include payment for any procedure covered by Medicare.

(j) At-home recovery benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(i) For purposes of this benefit, the following definitions apply:

(A) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(B) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(C) "Home" means any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility is not considered the insured's place of residence.

(D) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a twenty-four hour period of services provided by a care provider is one visit.

(ii) Coverage requirements and limitations.

(A) At-home recovery services provided must be primarily services that assist in activities of daily living.

(B) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(C) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits may not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars per visit.

(III) One thousand six hundred dollars per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in this section.

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no

more than eight weeks after the service date of the last Medicare approved home health care visit.

(iii) Coverage is excluded for: Home care visits paid for by Medicare or other government programs; and care provided by family members, unpaid volunteers, or providers who are not care providers.

((~~(3)~~)) (4) Standardized Medicare supplement benefit plan "K" must consist of the following:

(a) Coverage of one hundred percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

(b) Coverage of one hundred percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A deductible: Coverage for fifty percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (j) of this subsection;

(e) Skilled nursing facility care: Coverage for fifty percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in (j) of this subsection;

(f) Hospice care: Coverage for fifty percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in (j) of this subsection;

(g) Coverage for fifty percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulation) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (j) of this subsection;

(h) Except for coverage provided in (i) of this subsection, coverage for fifty percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (j) of this subsection;

(i) Coverage of one hundred percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of one hundred percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

((~~(4)~~)) (5) Standardized Medicare supplement benefit plan "L" must consist of the following:

(a) The benefits described in subsection ((~~(3)~~)) (4)(a), (b), (c) and (i) of this section;

(b) The benefit described in subsection ((~~(3)~~)) (4)(d), (e), (f) and (h) of this section but substituting seventy-five percent for fifty percent; and

(c) The benefit described in subsection ((~~(3)~~)) (4)(j) of this section but substituting two thousand dollars for four thousand dollars.

AMENDATORY SECTION (Amending Matter No. R 2004-08, filed 8/4/05, effective 9/4/05)

WAC 284-66-066 Standard Medicare supplement benefit plans. (1) An issuer must make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in WAC 284-66-063(2) of this regulation.

(2) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as permitted in WAC 284-66-066(7) and in WAC 284-66-073.

(3) Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans "A" through "L" listed in this subsection and conform to the definitions in WAC 284-66-030 and 284-66-040. Each benefit must be structured according to the format provided in WAC 284-66-063 (2), (3) ((~~or~~)), (4) or (5) and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of benefit.

(4) An issuer may use, in addition to the benefit plan designations required in subsection (3) of this section, other designations to the extent permitted by law.

(5) Make-up of benefit plans:

(a) Standardized Medicare supplement benefit plan "A" must be limited to only the basic ("core") benefits common to all benefit plans, as defined in WAC 284-66-063(2).

(b) Standardized Medicare supplement benefit plan "B" consists of only the following: The core benefit as defined in WAC 284-66-

063(2), plus the Medicare Part A deductible as defined in WAC 284-66-063 (3)(a).

(c) Standardized Medicare supplement benefit plan "C" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), and (h), respectively.

(d) Standardized Medicare supplement plan "D" consists of only the following: The core benefit, as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (h), and (j), respectively.

(e) Standardized Medicare supplement benefit plan "E" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in WAC 284-66-063 (3)(a), (b), (h), and (i), respectively.

(f) Standardized Medicare supplement benefit plan "F" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), (e), and (h), respectively.

(g) Standardized Medicare supplement benefit high deductible plan "F" consists of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), (e) and (h) respectively. The annual high deductible plan "F" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and must be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible is one thousand seven hundred thirty dollars for 2005, and is based on the calendar year. The deductible will be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(h) Standardized Medicare supplement benefit plan "G" consists of only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, eighty percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in WAC 284-66-063

(3)(a), (b), (d), (h), and (j), respectively.

(i) Standardized Medicare supplement benefit plan "H" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (f), and (h), respectively. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(j) Standardized Medicare supplement benefit plan "I" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (e), (f), (h), and (j), respectively. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(k) Standardized Medicare supplement benefit plan "J" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i), and (j), respectively. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(l) Standardized Medicare supplement benefit high deductible plan "J" consists of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventative medical care benefit and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i) and (j) respectively. The annual high deductible plan "J" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and must be in addition to any other specific benefit deductibles. The annual deductible is one thousand seven hundred thirty dollars for 2005, and is based on the calendar year. The deductible will be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31,

2005.

(6) Make-up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA):

(a) Standardized Medicare supplement benefit plan "K" consists of only those benefits described in WAC 284-66-063((~~(3)~~)) (4).

(b) Standardized Medicare supplement benefit plan "L" consists of only those benefits described in WAC 284-66-063((~~(4)~~)) (5).

(7) New or innovative benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefits may not include an outpatient prescription drug benefit.

AMENDATORY SECTION (Amending Matter No. R 2004-08, filed 8/4/05, effective 9/4/05)

WAC 284-66-092 Form of "outline of coverage." (1) Cover page.

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page:
Benefit Plan(s)___[insert letter(s) of plan(s) being offered]

See Outlines of Coverage sections for details about ALL plans

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

Basic Benefits for Plans A-J

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

A	B	C	D	E	F/F*	G	H	I	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)

A	B	C	D	E	F/F*	G	H	I	J*
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as plans F and J after one has paid a calendar year [$] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [$]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.
[Company Name] does not offer the [high deductible plan F] [high deductible plan J] [high deductible plan F or J].

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page 2

Basic Benefits for plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End
	50% Hospice cost-sharing	75% Hospice cost-sharing
	50% of Medicare-eligible expenses for the first three pints of blood	75% of Medicare-eligible expenses for the first three pints of blood
	50% Part B Coinsurance, except 100% Coinsurance for Part B Preventative Services	75% Part B Coinsurance, except 100% Coinsurance for Part B Preventative Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventative Care NOT covered by Medicare		
	$[ ] Out-of-Pocket Annual Limit***	$[ ] Out-of-Pocket Annual Limit***

**Plan K and L provide for different cost-sharing for items and services A-J.
Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.
***The out-of-pocket annual limit will increase each year for inflation.
See Outlines of Coverage for details and exceptions.

(2) Disclosure page(s):

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state.

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within thirty days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a

chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts as noted in WAC 284-66-066(4).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

(3) Charts displaying the feature of each benefit plan offered by the issuer:

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$0	$[ ] (Part A deductible)
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	$0	Up to $[ ] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-- TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN A

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)

Remainder of Medicare approved amounts	80%	20%	$0

PLAN B

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	$0	Up to $[ ] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN B

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN C

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment			
First $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

PLAN C (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0 ((E))
- - - Durable medical equipment	$0	$0	$[ ] (Part B deductible)
First $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
- - - Benefit for each visit	$0	Actual charges to $40 a visit	Balance
- - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
- - - Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN E

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN E

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN E (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE ((~~MEDICARE~~)) <u>MEDICAL</u> CARE BENEFIT - NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

[PLAN F] [HIGH DEDUCTIBLE PLAN F]

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[ ] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[ ]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0***
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

[PLAN F] [HIGH DEDUCTIBLE PLAN F]

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as plan F after one has paid a calendar year $[ ] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are $[ ]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

[PLAN F] [HIGH DEDUCTIBLE PLAN F]

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE, **] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment First $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0

PLAN F (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE, **] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days		$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ]	$[ ] a day	$0
91st day and after:	All but $[ ] a day		
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	 $0 Generally 80% $0	 $0 Generally 20% 80%	 $[ ] (Part B deductible) $0 20%
BLOOD First 3 pints Next $[ ] of Medicare approved amounts* Remainder of Medicare approved amounts	$0 $0 80%	All costs $0 20%	$0 $[ ] (Part B deductible) $0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
- - - Benefit for each visit	$0	Actual charges to $40 a visit	Balance
- - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
- - - Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN H

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Part B excess charges (Above Medicare approved amounts)	$0	((~~100~~)) 0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN H

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN H (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN I

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0**
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN I

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN I (continued)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment First $[ ] of Medicare approved amounts*	$0	$0	$[ ] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
- - - Benefit for each visit	$0	Actual charges to $40 a visit	Balance

- - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
- - - Calendar year maximum	$0	$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges*	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

[PLAN J] [HIGH DEDUCTIBLE PLAN J]

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as plan J after one has paid a calendar year $[ ] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are $[ ]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Parts A and B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (Part A deductible)	$0
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0***
- - - Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE,**] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

[PLAN J] [HIGH DEDUCTIBLE PLAN J]

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as plan J after one has paid a calendar year $[ ] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are $[ ]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and B, but does not include the plan's separate foreign travel emergency deductible]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[ ] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[ ] DEDUCTIBLE,**] YOU PAY
Part B excess charges (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

[PLAN J] [HIGH DEDUCTIBLE PLAN J] (continued)

PARTS A & B

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment First $[ ] of Medicare approved amounts*	$0	$[ ] (Part B deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
- - - Benefit for each visit	$0	Actual charges to $40 a visit	Balance
- - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
- - - Calendar year maximum	$0	$1,600	

[PLAN J] [HIGH DEDUCTIBLE PLAN J]

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (50% of Part A deductible)	$[ ] (50% of Part A deductible)♦
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0***
- - - Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	Up to $[ ] a day♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts****	$0	$0	$[ ] (Part B deductible)****♦
Preventative Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare approved amounts	Generally 80%	Generally 10%	Generally 10%♦
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[ ])*
BLOOD			
First 3 pints	$0	50%	50%♦

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
Next $[ ] of Medicare approved amounts****	$0	$0	$[ ] (Part B deductible)****♦
Remainder of Medicare approved amounts	Generally 80%	Generally 10%	Generally 10%♦
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4000] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN K (continued)

PARTS A & B

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment First $[ ] of Medicare approved amounts*****	$0	$0	$[ ] (Part B deductible)♦
Remainder of Medicare approved amounts	80%	10%	10%♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

*You will pay ((~~half~~)) <u>one-fourth</u> the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION((*))** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[ ]	$[ ] (75% of Part A deductible)	$[ ] (25% of Part A deductible)♦
61st thru 90th day	All but $[ ] a day	$[ ] a day	$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but $[ ] a day	$[ ] a day	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	$0	100% of Medicare eligible expenses	$0***
- - - Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE__*__ You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[ ]/day	Up to $[ ] a day	Up to $[ ] a day♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	((~~75~~)) 25% of coinsurance or copayments♦

((~~*~~))**__*__**NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****__*__Once you have been billed $[ ] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[ ] of Medicare approved amounts****__*__	$0	$0	$[ ] (Part B deductible)****♦
Preventative Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare approved amounts	Generally 80%	Generally 15%	Generally 5%♦

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
Part B excess charges (Above Medicare approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[ ])*
BLOOD			
First 3 pints	$0	75%	25%♦
Next $[ ] of Medicare approved amounts****	$0	$0	$[ ] (Part B deductible)****♦
Remainder of Medicare approved amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[ ] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L (continued)

PARTS A & B

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	$0	$0
- - - Durable medical equipment First $[ ] of Medicare approved amounts****((*))	$0	$0	$[ ] (Part B deductible)♦
Remainder of Medicare approved amounts	80%	15%	5%♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

AMENDATORY SECTION (Amending Matter No. R 2004-08, filed 8/4/05, effective 9/4/05)

WAC 284-66-142 Form of replacement notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company name] Insurance Company. Your new policy will provide thirty days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other disability coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

____ Additional benefits.

____ No change in benefits, but lower premiums.

____ Fewer benefits and lower premiums.

____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

____ Disenrollment from a Medicare Advantage plan.

Please explain reason for disenrollment. [optional only for Direct Mailers]

____ Other. (please specify)

1. NOTE: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. If you have had your current Medicare supplement policy less than three months, health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

.....
(Signature of Agent, Broker, or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

.....
(Applicant's Signature)

.....
(Date)
*Signature not required for direct response sales.

AMENDATORY SECTION (Amending Matter No. R 2004-08, filed 8/4/05, effective 9/4/05)

WAC 284-66-160 Adjustment notice to conform existing Medicare supplement policies to changes in Medicare. As soon as practicable, but no later than thirty days before the effective date of any Medicare benefit changes, every ((~~insurer~~)) issuer providing Medicare supplement insurance coverage to a resident of this state must notify its insureds of modifications it has made to Medicare supplement policies. The adjustment notice is intended to be informational only and for the sole purpose of informing policyholders and certificate holders about changes in Medicare benefits, indexed deductible and copayment provisions, premium adjustments, and the like. The form of an adjustment notice provided to residents of this state must be filed with the commissioner before being used.

(1) The notice must include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy.

(2) The notice must inform each covered person of the

approximate date when premium adjustments due to changes in Medicare benefits will be made.

(3) The notice of benefit modifications and any premium changes must be furnished in outline form and in clear and simple terms so as to facilitate comprehension.

(4) The notice must not contain or be accompanied by any solicitation.

(5) Issuers must comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.